Arizona Technology Council AHP
PPO 90 500 Plan Attachment

Your Cost-Sharing Information

azblue.com/MyBlue
YOUR PLAN NETWORK

Your Summary of Benefits and Coverage (SBC) and ID card show the name of the plan network that applies to your benefit plan. You’ll find the complete directory of providers in your plan’s network at azblue.com/MyBlue. If you do not have Internet access, would like to request a paper copy of the directory, or have questions about whether or not a certain provider is in the network, please call Blue Cross® Blue Shield® of Arizona (BCBSAZ) Customer Service at the number on your ID card. It’s important to make sure your provider is in your plan network before you receive services.

MEMBER COST SHARING & OTHER PAYMENTS

As explained in your Base Benefit Book, your cost share is the cost you pay for the covered healthcare services you use. Depending on your particular benefit plan, the service you receive, and the provider you choose, your cost share can include an access fee, balance bill, coinsurance, copay, deductible, precertification charge, or a combination of these types of payments (we explain these terms in the Base Benefit Book as well). The following table and your SBC explain which cost-share and other payment types apply to each benefit.

BCBSAZ uses your claims to track your progress toward meeting your cost-share obligations. We track the claims based on the order in which we process them, and not based on when you received the service.

COST-SHARE TABLE

<table>
<thead>
<tr>
<th>Type of Cost Share</th>
<th>In-Network Cost Share</th>
<th>Out-of-Network Cost Share</th>
</tr>
</thead>
<tbody>
<tr>
<td>Plan-Year Deductible</td>
<td>$1,000 per member</td>
<td>$2,000 per family</td>
</tr>
<tr>
<td>Out-of-Pocket Maximum</td>
<td>$4,000 per member</td>
<td>$8,000 per member</td>
</tr>
<tr>
<td></td>
<td>$8,000 per family</td>
<td>$16,000 per family</td>
</tr>
</tbody>
</table>

Until you meet your deductible, you will pay the allowed amount for most services, plus the balance bill for out-of-network services (see the “Know the Lingo” section and Appendix A of your Base Benefit Book for definitions of any italicized terms that are not defined here). For services that require a copay, the deductible is waived. Note that any access fees you see listed here do not count toward your deductible.

<table>
<thead>
<tr>
<th>Benefit</th>
<th>In-Network Cost Share</th>
<th>Out-of-Network Cost Share</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ambulance Services</td>
<td>10% coinsurance</td>
<td>50% coinsurance + balance bill</td>
</tr>
<tr>
<td>Behavioral Health Services Inpatient facility &amp; professional services</td>
<td>10% coinsurance</td>
<td>50% coinsurance + balance bill</td>
</tr>
<tr>
<td>Behavioral Health Services Outpatient facility &amp; professional services</td>
<td>$20 copay for PCP office visits</td>
<td>50% coinsurance + balance bill</td>
</tr>
<tr>
<td>Behavioral Therapy Services for the Treatment of Autism Spectrum Disorder</td>
<td>$20 copay for PCP office visits</td>
<td>50% coinsurance + balance bill</td>
</tr>
<tr>
<td>Cardiac &amp; Pulmonary Rehabilitation Outpatient services</td>
<td>$20 copay for PCP office visits</td>
<td>50% coinsurance + balance bill</td>
</tr>
<tr>
<td>Benefit</td>
<td>In-Network Cost Share</td>
<td>Out-of-Network Cost Share</td>
</tr>
<tr>
<td>---------------------------------------------</td>
<td>---------------------------------------------------------------------------------------</td>
<td>----------------------------------------------------------------</td>
</tr>
<tr>
<td>Cataract Surgery &amp; Keratoconus</td>
<td>$20 copay for PCP office visits</td>
<td>50% coinsurance (after deductible) + balance bill</td>
</tr>
<tr>
<td></td>
<td>$40 copay for specialist office visits</td>
<td></td>
</tr>
<tr>
<td></td>
<td>10% coinsurance (after deductible) for professional services you receive at an inpatient or outpatient facility, and any related facility charges</td>
<td></td>
</tr>
<tr>
<td>Chiropractic Services</td>
<td>$40 specialist copay per member, per provider, per day for services you receive during an office, home, or walk-in clinic visit</td>
<td>50% coinsurance (after deductible) + balance bill</td>
</tr>
<tr>
<td></td>
<td>10% coinsurance (after deductible) for:</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Visits in which you receive only physical medicine and rehabilitation services and no other covered service</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Chiropractic services delivered at other locations</td>
<td></td>
</tr>
<tr>
<td>Clinical Trials</td>
<td>$20 copay for PCP office visits</td>
<td>50% coinsurance (after deductible) + balance bill</td>
</tr>
<tr>
<td></td>
<td>$40 copay for specialist office visits 10% coinsurance (after deductible) for professional services you receive at an inpatient or outpatient facility, and any related facility charges</td>
<td></td>
</tr>
<tr>
<td>Dental Services—Medical</td>
<td>10% coinsurance (after deductible)</td>
<td>50% coinsurance (after deductible) + balance bill</td>
</tr>
<tr>
<td>Durable Medical Equipment (DME), Medical Supplies, &amp; Prosthetic Appliances &amp; Orthotics</td>
<td>$20 copay for PCP office visits</td>
<td>50% coinsurance (after deductible) + balance bill</td>
</tr>
<tr>
<td></td>
<td>$40 copay for specialist office visits</td>
<td></td>
</tr>
<tr>
<td></td>
<td>10% coinsurance (after deductible) for:</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• DME picked up at the doctor’s office but billed through a DME supplier. If you have a doctor’s office visit at the time you pick up your DME, medical supplies, prosthetic appliance, or orthotics, you also pay the PCP or specialist copay.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Services you receive at locations other than a doctor’s office</td>
<td></td>
</tr>
<tr>
<td></td>
<td>$0 for one FDA-approved manual or electric breast pump and breast pump supplies per member, per plan year</td>
<td></td>
</tr>
<tr>
<td>Education &amp; Training</td>
<td>$0</td>
<td>50% coinsurance (after deductible) + balance bill</td>
</tr>
<tr>
<td>Diabetes &amp; asthma education &amp; training, nutritional counseling &amp; training</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Emergency Services</td>
<td>You pay your in-network cost share for emergency services, even for services from out-of-network providers.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Emergency Room (ER)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>$300 ER copay per member, per facility, per day</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Admission to the Hospital From the ER</td>
<td></td>
</tr>
<tr>
<td></td>
<td>If you are admitted as an inpatient:</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• $0 ER copay</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• 10% coinsurance (after in-network deductible) for facility and ancillary services related to the emergency, including facility and ancillary services you receive while you are in the ER, and for emergency professional services you receive after admission</td>
<td></td>
</tr>
<tr>
<td>Benefit</td>
<td>In-Network Cost Share</td>
<td>Out-of-Network Cost Share</td>
</tr>
<tr>
<td>-------------------------------------------</td>
<td>--------------------------------------------------</td>
<td>----------------------------------------------------------------</td>
</tr>
<tr>
<td><strong>If you are admitted for observation or as an outpatient:</strong></td>
<td>If you receive emergency services from a noncontracted facility or professional provider, BCBSAZ will base the allowed amount used to calculate your cost share on the highest of the following three amounts, not to exceed the applicable provider’s billed charges:</td>
<td></td>
</tr>
<tr>
<td>• $300 ER copay</td>
<td>The median in-network provider negotiated rate for the emergency services furnished,</td>
<td></td>
</tr>
<tr>
<td>• 10% coinsurance (after in-network deductible) for professional, facility, and ancillary services you receive that are related to the emergency, and for any related services you receive after you are admitted for observation, or as an outpatient</td>
<td>The cost of the emergency services as calculated using the same method BCBSAZ generally uses to determine reimbursement for out-of-network services, or</td>
<td></td>
</tr>
<tr>
<td>• 10% coinsurance (after in-network deductible) for professional, facility, and ancillary services you receive that are related to the emergency, and for any related services you receive after you are admitted for observation, or as an outpatient</td>
<td>The amount that would be paid by Medicare Part A or B.</td>
<td></td>
</tr>
<tr>
<td><strong>If you receive emergency services from a noncontracted facility or professional provider,</strong></td>
<td>For all non-emergency services following the emergency treatment and stabilization:</td>
<td></td>
</tr>
<tr>
<td>BCBSAZ will base the allowed amount used to calculate your cost share on the highest of the following three amounts, not to exceed the applicable provider’s billed charges:</td>
<td>The cost-share amount will depend on the provider’s network status and the place you receive services</td>
<td></td>
</tr>
<tr>
<td>• The median in-network provider negotiated rate for the emergency services furnished,</td>
<td>If you receive non-emergency services from a noncontracted provider, you also pay the balance bill, which may be substantial</td>
<td></td>
</tr>
<tr>
<td>• The cost of the emergency services as calculated using the same method BCBSAZ generally uses to determine reimbursement for out-of-network services, or</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• The amount that would be paid by Medicare Part A or B.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Eosinophilic Gastrointestinal Disorder</strong></td>
<td><strong>Family Planning</strong></td>
<td><strong>Hospice Services</strong></td>
</tr>
<tr>
<td><strong>(EGID)</strong></td>
<td><strong>Cost is defined here as either the allowed amount, if the formula is purchased from an in-network provider, or billed charges, if purchased from an out-of-network provider.</strong></td>
<td><strong>$0 + balance bill</strong></td>
</tr>
<tr>
<td><strong>10% of the cost of formula</strong></td>
<td><strong>Contraceptives &amp; sterilization</strong></td>
<td><strong>50% coinsurance (after deductible) + balance bill</strong></td>
</tr>
<tr>
<td><strong>Deductible is waived</strong></td>
<td><strong>Cost is defined here as either the allowed amount, if the formula is purchased from an in-network provider, or billed charges, if purchased from an out-of-network provider.</strong></td>
<td><strong>50% coinsurance (after deductible) + balance bill</strong></td>
</tr>
<tr>
<td><strong>Family Planning</strong></td>
<td><strong>Home Health Services</strong></td>
<td><strong>50% coinsurance (after deductible) + balance bill</strong></td>
</tr>
<tr>
<td><strong>Contraceptives &amp; sterilization</strong></td>
<td><strong>10% coinsurance (after deductible)</strong></td>
<td><strong>50% coinsurance (after deductible) + balance bill</strong></td>
</tr>
<tr>
<td><strong>$0 for professional charges for implantation</strong></td>
<td><strong>Hospice Services</strong></td>
<td><strong>50% coinsurance (after deductible) + balance bill</strong></td>
</tr>
<tr>
<td><strong>and/or removal (including follow-up care)</strong></td>
<td><strong>$0 for professional charges for implantation</strong></td>
<td><strong>50% coinsurance (after deductible) + balance bill</strong></td>
</tr>
<tr>
<td><strong>of FDA-approved female implanted</strong></td>
<td><strong>$0 for professional charges for implantation</strong></td>
<td><strong>50% coinsurance (after deductible) + balance bill</strong></td>
</tr>
<tr>
<td><strong>contraceptive (birth control) devices when</strong></td>
<td><strong>$0 for professional charges for implantation</strong></td>
<td><strong>50% coinsurance (after deductible) + balance bill</strong></td>
</tr>
<tr>
<td><strong>the purpose of the procedure is</strong></td>
<td><strong>$0 for professional charges for implantation</strong></td>
<td><strong>50% coinsurance (after deductible) + balance bill</strong></td>
</tr>
<tr>
<td><strong>contraception, as documented by your</strong></td>
<td><strong>$0 for professional charges for implantation</strong></td>
<td><strong>50% coinsurance (after deductible) + balance bill</strong></td>
</tr>
<tr>
<td><strong>doctor on the claim submitted to BCBSAZ</strong></td>
<td><strong>$0 for professional charges for implantation</strong></td>
<td><strong>50% coinsurance (after deductible) + balance bill</strong></td>
</tr>
<tr>
<td><strong>$0 for professional and facility charges for</strong></td>
<td><strong>$0 for professional and facility charges for</strong></td>
<td><strong>50% coinsurance (after deductible) + balance bill</strong></td>
</tr>
<tr>
<td><strong>FDA-approved female sterilization</strong></td>
<td><strong>FDA-approved female sterilization</strong></td>
<td><strong>50% coinsurance (after deductible) + balance bill</strong></td>
</tr>
<tr>
<td><strong>procedures when the purpose of the</strong></td>
<td><strong>procedures when the purpose of the</strong></td>
<td><strong>50% coinsurance (after deductible) + balance bill</strong></td>
</tr>
<tr>
<td><strong>procedure is contraception, as documented</strong></td>
<td><strong>procedure is contraception, as documented</strong></td>
<td><strong>50% coinsurance (after deductible) + balance bill</strong></td>
</tr>
<tr>
<td><strong>by your doctor on the claim submitted to</strong></td>
<td><strong>by your doctor on the claim submitted to</strong></td>
<td><strong>50% coinsurance (after deductible) + balance bill</strong></td>
</tr>
<tr>
<td><strong>BCBSAZ</strong></td>
<td><strong>BCBSAZ</strong></td>
<td><strong>50% coinsurance (after deductible) + balance bill</strong></td>
</tr>
<tr>
<td><strong>$0 for female oral contraceptives, patches,</strong></td>
<td><strong>$0 for female oral contraceptives, patches,</strong></td>
<td><strong>50% coinsurance (after deductible) + balance bill</strong></td>
</tr>
<tr>
<td><strong>rings, and contraceptive injections</strong></td>
<td><strong>rings, and contraceptive injections</strong></td>
<td><strong>50% coinsurance (after deductible) + balance bill</strong></td>
</tr>
<tr>
<td><strong>$0 for FDA-approved over-the-counter</strong></td>
<td><strong>emergency contraception that is prescribed</strong></td>
<td><strong>50% coinsurance (after deductible) + balance bill</strong></td>
</tr>
<tr>
<td><strong>emergency contraception that is prescribed</strong></td>
<td><strong>by a doctor or other healthcare provider</strong></td>
<td><strong>50% coinsurance (after deductible) + balance bill</strong></td>
</tr>
<tr>
<td><strong>by a doctor or other healthcare provider</strong></td>
<td><strong>by a doctor or other healthcare provider</strong></td>
<td><strong>50% coinsurance (after deductible) + balance bill</strong></td>
</tr>
<tr>
<td><strong>$0 for diaphragms, cervical caps,</strong></td>
<td><strong>$0 for diaphragms, cervical caps,</strong></td>
<td><strong>50% coinsurance (after deductible) + balance bill</strong></td>
</tr>
<tr>
<td><strong>cervical shields,</strong></td>
<td><strong>cervical shields,</strong></td>
<td><strong>50% coinsurance (after deductible) + balance bill</strong></td>
</tr>
<tr>
<td><strong>female condoms,</strong></td>
<td><strong>female condoms,</strong></td>
<td><strong>50% coinsurance (after deductible) + balance bill</strong></td>
</tr>
<tr>
<td><strong>sponges, and spermicides</strong></td>
<td><strong>sponges, and spermicides</strong></td>
<td><strong>50% coinsurance (after deductible) + balance bill</strong></td>
</tr>
<tr>
<td><strong>10% coinsurance (after deductible)</strong></td>
<td><strong>10% coinsurance (after deductible)</strong></td>
<td><strong>50% coinsurance (after deductible) + balance bill</strong></td>
</tr>
<tr>
<td><strong>for FDA-approved male sterilization</strong></td>
<td><strong>for FDA-approved male sterilization</strong></td>
<td><strong>50% coinsurance (after deductible) + balance bill</strong></td>
</tr>
<tr>
<td><strong>procedures</strong></td>
<td><strong>procedures</strong></td>
<td><strong>50% coinsurance (after deductible) + balance bill</strong></td>
</tr>
<tr>
<td><strong>Home Health Services</strong></td>
<td><strong>Inpatient &amp; Outpatient Detoxification Services</strong></td>
<td><strong>50% coinsurance (after deductible) + balance bill</strong></td>
</tr>
<tr>
<td><strong>10% coinsurance (after deductible)</strong></td>
<td><strong>$20 copay for PCP office visits</strong></td>
<td><strong>50% coinsurance (after deductible) + balance bill</strong></td>
</tr>
<tr>
<td><strong>50% coinsurance (after deductible) +</strong></td>
<td><strong>$40 copay for specialist office visits</strong></td>
<td><strong>50% coinsurance (after deductible) + balance bill</strong></td>
</tr>
<tr>
<td><strong>balance bill</strong></td>
<td><strong>10% coinsurance (after deductible) for</strong></td>
<td><strong>50% coinsurance (after deductible) + balance bill</strong></td>
</tr>
<tr>
<td><strong>services you receive at other locations</strong></td>
<td><strong>services you receive at other locations</strong></td>
<td><strong>50% coinsurance (after deductible) + balance bill</strong></td>
</tr>
</tbody>
</table>

**Eosinophilic Gastrointestinal Disorder (EGID)**

<table>
<thead>
<tr>
<th>Benefit</th>
<th>In-Network Cost Share</th>
<th>Out-of-Network Cost Share</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>10% of the cost of formula</strong></td>
<td><strong>Deductible is waived</strong></td>
<td><strong>25% of the cost of formula</strong></td>
</tr>
<tr>
<td><strong>Deductible is waived</strong></td>
<td><strong>Deductible is waived</strong></td>
<td><strong>Deductible is waived</strong></td>
</tr>
</tbody>
</table>

**Family Planning**

**Contraceptives & sterilization**

**Inpatient & Outpatient Detoxification Services**

**Hospice Services**

2021 AZTC AHP PPO 90 1000
<table>
<thead>
<tr>
<th>Benefit</th>
<th>In-Network Cost Share</th>
<th>Out-of-Network Cost Share</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Inpatient Hospital</strong></td>
<td>10% coinsurance (after deductible) $0 for professional and facility charges for FDA-approved female sterilization procedures when the purpose of the procedure is contraception, as documented by your provider on the claim submitted to BCBSAZ</td>
<td>50% coinsurance (after deductible) + balance bill</td>
</tr>
<tr>
<td></td>
<td>$1,000 bariatric surgery access fee plus applicable deductible and coinsurance for all bariatric surgeries. The access fee applies toward the professional charges for bariatric surgery.</td>
<td></td>
</tr>
<tr>
<td><strong>Inpatient Rehabilitation Services—Extended Active Rehabilitation (EAR) Services</strong></td>
<td>10% coinsurance (after deductible) for the first 60 days of services in a plan year  50% coinsurance (after deductible) for the second 60 days of services in a plan year. If your claim is submitted with a primary mental health and/or substance use disorder diagnosis, you will pay the cost share applicable to the first 60 days of services in a plan year.</td>
<td>50% coinsurance (after deductible) + balance bill</td>
</tr>
<tr>
<td><strong>Long-Term Acute Care</strong></td>
<td>10% coinsurance (after deductible) for the first 100 days of services 50% coinsurance (after deductible) for days 101-365 of services. If your claim is submitted with a primary mental health and/or substance use disorder diagnosis, you will pay the cost share applicable to the first 100 days of services.</td>
<td>50% coinsurance (after deductible) + balance bill</td>
</tr>
<tr>
<td><strong>Maternity</strong></td>
<td>$20 PCP copay or $40 specialist copay for your first prenatal office or home visit, which covers all services included in the provider’s global charge. One copay, per member, per provider, per day for other doctor’s office or home visits not included in the global charge. 10% coinsurance (after deductible) for professional services you receive at an inpatient or outpatient facility, and any related facility charges</td>
<td>50% coinsurance (after deductible) + balance bill</td>
</tr>
<tr>
<td><strong>Medical Foods for Inherited Metabolic Disorders</strong></td>
<td>10% of the cost of medical foods Deductible is waived</td>
<td>50% of the cost of medical foods Deductible is waived</td>
</tr>
<tr>
<td></td>
<td>Cost is defined here as either the allowed amount, if the member buys the medical foods from an in-network provider, or billed charges, if the member buys the medical foods from an out-of-network provider.</td>
<td></td>
</tr>
<tr>
<td><strong>Neuropsychological &amp; Cognitive Testing</strong></td>
<td>$20 copay for PCP office visits $40 copay for specialist office visits 10% coinsurance (after deductible) for professional services you receive at an inpatient or outpatient facility, and any related facility charges</td>
<td>50% coinsurance (after deductible) + balance bill</td>
</tr>
<tr>
<td>Benefit</td>
<td>In-Network Cost Share</td>
<td>Out-of-Network Cost Share</td>
</tr>
<tr>
<td>---------</td>
<td>----------------------</td>
<td>---------------------------</td>
</tr>
<tr>
<td><strong>Diagnostic Laboratory Services:</strong></td>
<td></td>
<td>$1,000 bariatric surgery access fee plus applicable deductible and coinsurance for all bariatric surgeries. The access fee applies toward the professional charges for bariatric surgery.</td>
</tr>
<tr>
<td>• $20 PCP copay or $40 specialist copay for in-office doctor visits (waived if you receive only covered lab services during your visit)</td>
<td></td>
<td>50% coinsurance (after deductible) + balance bill</td>
</tr>
<tr>
<td>• 10% coinsurance (after deductible) for professional services you receive from a pathologist or dermapathologist, and for services provided at locations other than a doctor’s office</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Radiology Services:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• $20 PCP copay or $40 specialist copay for in-office doctor visits</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• 10% coinsurance (after deductible) for professional services you receive from a radiologist, and for services provided at locations other than a doctor’s office</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Outpatient Services</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Outpatient Facility Services (including outpatient surgery):</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• 10% coinsurance (after deductible)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• $0 for FDA-approved female sterilization procedures when the purpose of the procedure is contraception, as documented by your provider on the claim submitted to BCBSAZ</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Sleep Studies:</strong> 10% coinsurance (after deductible)</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Medications Given to You at an Outpatient Facility:</strong> 10% coinsurance (after deductible)</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Pharmacy &amp; Medications Benefits</strong> (next two rows)</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Note:</strong> Your cost share for any medication is based on the level to which BCBSAZ has assigned it at the time the prescription is filled. No exceptions will be made regarding the assigned level of a medication. BCBSAZ may change the level of a medication at any time without notice. To confirm the status and level of a particular medication, visit MyBlue, or call Pharmacy Benefit Customer Service at the number on your ID card.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Pharmacy Benefit**

See Appendix B in your Base Benefit Book for details about your Pharmacy benefits, including how your cost share is calculated.

<table>
<thead>
<tr>
<th>Retail Pharmacy Medications (30-day supply)</th>
<th>Mail-Order Medications (90-day supply)</th>
<th>Specialty Medications</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Level 1: $15 copay</td>
<td>• Level 1: $30 copay</td>
<td>• Level A: $60 copay</td>
</tr>
<tr>
<td>• Level 2: $45 copay</td>
<td>• Level 2: $90 copay</td>
<td>• Level B: $110 copay</td>
</tr>
<tr>
<td>• Level 3: $75 copay</td>
<td>• Level 3: $150 copay</td>
<td>• Level C: $160 copay</td>
</tr>
<tr>
<td>• Level 4 (including compounded medications): $130 copay</td>
<td>• Level 4: $260 copay</td>
<td>• Level D: $210 copay</td>
</tr>
</tbody>
</table>

The following are **not covered** when obtained from out-of-network pharmacies:

- 90-day supply at retail
- Mail-order medications
- Specialty medications

**You must pay the full cost for retail prescriptions purchased from an out-of-network pharmacy and submit a claim to BCBSAZ.** You will be reimbursed at the in-network level of benefits, up to the allowed amount. You will be responsible for any balance bill, including the difference between the allowed amounts for the generic and brand name medications.
<table>
<thead>
<tr>
<th>Benefit</th>
<th>In-Network Cost Share</th>
<th>Out-of-Network Cost Share</th>
</tr>
</thead>
<tbody>
<tr>
<td>You may obtain up to a 90-day supply of covered maintenance medications at a network retail pharmacy (keep in mind that not all medications are available for more than a 30- or 60-day supply). If you receive a 31- to 60-day supply of medication, you will pay two times the applicable cost share for a 30-day supply. If you receive a 61- to 90-day supply of medication from a network retail pharmacy, you will pay three times the 30-day cost share. Your cost share will be different depending on the type of pharmacy, how much of the medication you’re getting, and the level of the medication. If you purchase a brand-name medication when a generic equivalent is available, you will pay the level 1 copay plus the difference between the allowed amounts for the generic and brand-name medications, even if the prescribing provider indicates on the prescription that the brand-name medication is what you should have. If you have completed step therapy and are taking a brand-name drug with a generic equivalent as a result of the step-therapy process, you pay the cost share that applies to the brand-name medication. $0 for preventive medications and for covered vaccines. BCBSAZ determines: • Which medications are considered preventive, • Which vaccines are covered, and • For which there is a $0 cost share $0 for the generic version of certain covered preventive medications or items; applicable cost share for the brand-name version. You may request an exception for waiver of cost share (see “Preventive Services” in section 2 of your Base Benefit Book) for the brand-name version of a preventive medication or item. $0 for the following female contraceptive (birth control) methods when prescribed by your provider for the purpose of contraception and obtained from an in-network pharmacy: • FDA-approved brand oral, patch, vaginal ring, and injectable contraceptives with no generic equivalent components • FDA-approved diaphragms, cervical caps, and cervical shields • FDA-approved emergency contraception for members of any age • FDA-approved generic oral, patch, vaginal ring, and injectable contraceptives • Female condoms • Sponges and spermicides</td>
<td>To find cost information for a medication: • Log in to MyBlue. • Under “Pharmacy,” click Prescription Benefits &amp; Tools to go to the “My Medicine Cabinet” page • At the top of the page, select “Member Tools &gt; Drug Pricing”</td>
<td></td>
</tr>
<tr>
<td>Benefit</td>
<td>In-Network Cost Share</td>
<td>Out-of-Network Cost Share</td>
</tr>
<tr>
<td>-------------------------------</td>
<td>---------------------------------------------------</td>
<td>-------------------------------------------------</td>
</tr>
<tr>
<td>Medications for the Treatment of Cancer</td>
<td>10% coinsurance (after deductible) for medications you receive through your medical benefits</td>
<td>50% coinsurance (after deductible) + balance bill</td>
</tr>
</tbody>
</table>

For certain cancer treatment medications, as determined by BCBSAZ, you will receive a *15-day supply*, and pay **one-half of the level 1** retail pharmacy copay the first time you receive the medication. You will be able to refill the medication every 15 days, and you will continue to pay one-half of the level 1 retail pharmacy copay for each refill during your first three months of treatment with the medication. If you have side effects from the medication during the three-month period, your prescribing doctor may change your medication. If you tolerate the medication, you will be able to refill the cancer treatment medication for up to 30 days after three months of treatment.

**Physical Therapy (PT), Occupational Therapy (OT), & Speech Therapy (ST) Services**

<table>
<thead>
<tr>
<th>In-Network Cost Share</th>
<th>Out-of-Network Cost Share</th>
</tr>
</thead>
<tbody>
<tr>
<td>10% coinsurance (after deductible)</td>
<td>50% coinsurance (after deductible) + balance bill</td>
</tr>
</tbody>
</table>

One $20 PCP copay or one $40 specialist copay per member, per provider, per day for services you receive during an office, home, or walk-in clinic visit.

$0 if you only receive the following services and no other covered service during your home or office visit:
- Covered allergy injections
- Covered immunizations
- Covered laboratory services

$0 for the following, when the purpose is female contraception (birth control), as documented by your provider on the claim submitted to BCBSAZ:
- Professional services for FDA-approved female sterilization procedures, regardless of the location of service
- Professional services for fitting, implantation, and/or removal (including follow-up care) of FDA-approved contraceptive devices
- FDA-approved implanted contraceptive devices
- The following FDA-approved generic and brand-with-no-generic-equivalent prescription hormonal and barrier contraceptive methods and devices: patches, rings, contraceptive injections, diaphragms, cervical caps, cervical shields, female condoms, sponges, and spermicides

**Physician Services**

If you receive preventive services from an in-network doctor, your cost share may be waived.

<table>
<thead>
<tr>
<th>In-Network Cost Share</th>
<th>Out-of-Network Cost Share</th>
</tr>
</thead>
<tbody>
<tr>
<td>50% coinsurance (after deductible) + balance bill</td>
<td></td>
</tr>
</tbody>
</table>

10% coinsurance (after deductible) for:
- Covered PT, OT, and ST
- PCP and specialist services provided at locations other than a doctor’s office, home, or walk-in clinic
- Professional services you receive from a radiologist or pathologist, including a dermapathologist, and for professional services you receive that are related to a sleep study, even when the services are provided at a doctor’s office
- Medications given to you at a doctor’s office

See the “Outpatient Services” row above for more information on cost-share amounts for covered services.
<table>
<thead>
<tr>
<th>Benefit</th>
<th>In-Network Cost Share</th>
<th>Out-of-Network Cost Share</th>
</tr>
</thead>
<tbody>
<tr>
<td>Post-Mastectomy Services</td>
<td>$20 copay for PCP office visits</td>
<td>50% coinsurance (after deductible) + balance bill</td>
</tr>
<tr>
<td></td>
<td>$40 copay for specialist office visits</td>
<td></td>
</tr>
<tr>
<td></td>
<td>10% coinsurance (after deductible) for professional services you receive at an inpatient or outpatient facility, and any related facility charges</td>
<td></td>
</tr>
<tr>
<td>Pregnancy, Termination</td>
<td>$20 copay for PCP office visits</td>
<td>50% coinsurance (after deductible) + balance bill</td>
</tr>
<tr>
<td></td>
<td>$40 copay for specialist office visits</td>
<td></td>
</tr>
<tr>
<td></td>
<td>10% coinsurance (after deductible) for professional services you receive at an inpatient or outpatient facility, and any related facility charges</td>
<td></td>
</tr>
<tr>
<td>Preventive Services</td>
<td>$0 regardless of the location where services are provided if:</td>
<td>50% coinsurance (after deductible) + balance bill for mammography services and foreign travel immunizations</td>
</tr>
<tr>
<td></td>
<td>• You receive one of the services covered as explained in the “Preventive Services” section of your Base Benefit Book;</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• The procedure code, the diagnosis code, or the combination of procedure and diagnosis codes billed by your provider on the claim indicates the service is preventive; and</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• The primary purpose of the visit at which you received the services was preventive care</td>
<td></td>
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<tr>
<td></td>
<td>$0 for the generic version of certain covered preventive medications or items; applicable cost share for the brand-name version. You may request an exception for waiver of cost share (see “Preventive Services” in section 2 of your Base Benefit Book) for the brand-name version of a preventive medication or item.</td>
<td></td>
</tr>
<tr>
<td>Reconstructive Surgery &amp;</td>
<td>$20 copay for PCP office visits</td>
<td>50% coinsurance (after deductible) + balance bill</td>
</tr>
<tr>
<td>Services</td>
<td>$40 copay for specialist office visits</td>
<td></td>
</tr>
<tr>
<td></td>
<td>10% coinsurance (after deductible) for professional services you receive at an inpatient or outpatient facility, and any related facility charges</td>
<td></td>
</tr>
<tr>
<td>Skilled Nursing Facility (SNF)</td>
<td>10% coinsurance (after deductible) for the first 90 days of services in a plan year</td>
<td>50% coinsurance (after deductible) + balance bill</td>
</tr>
<tr>
<td></td>
<td>50% coinsurance (after deductible) for the second 90 days of services in a plan year.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>If your claim is submitted with a primary mental health and/or substance use disorder diagnosis, you will pay the cost share applicable to the first 90 days of services in a plan year.</td>
<td></td>
</tr>
<tr>
<td>Telehealth Services</td>
<td>$0 copay for telehealth medical consultations</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>$20 copay for telehealth counseling sessions provided by a counselor</td>
<td></td>
</tr>
<tr>
<td></td>
<td>$40 copay for telehealth psychiatric consultations provided by a psychiatrist</td>
<td></td>
</tr>
</tbody>
</table>

*Telehealth services are video consultations you have with a provider using BCBSAZ’s BlueCare Anywhere℠ service.*
<table>
<thead>
<tr>
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<tbody>
<tr>
<td><strong>Telemedicine Services</strong></td>
<td>For any telemedicine service, you pay the same cost-share amount as if the service were provided in person. Cost-share applies for the service provided at your physical location, and also for the service rendered remotely by the telemedicine provider. <strong>Example:</strong> If you are at a PCP’s office and receiving a consultation from a remote specialist, you will pay the cost share for the PCP office visit and the cost share for the specialist office visit or consultation. If you are at home and receiving a consultation from a remote specialist, you would pay only the cost share for the specialist because no other provider is involved at your location.</td>
<td><strong>Not covered, except for emergency and urgent services.</strong> In those cases, you pay the cost-share amounts applicable to all services provided via telemedicine. You will always pay in-network cost share for emergency services provided via telemedicine.</td>
</tr>
<tr>
<td><strong>Transplant &amp; Gene Therapy</strong></td>
<td><strong>$0</strong></td>
<td></td>
</tr>
<tr>
<td>Travel &amp; Lodging</td>
<td>Maximum reimbursement of $10,000 per member, per transplant or gene therapy treatment</td>
<td></td>
</tr>
<tr>
<td><strong>Transplants</strong></td>
<td><strong>$20 copay</strong> for PCP office visits</td>
<td><strong>50% coinsurance (after deductible) + balance bill</strong></td>
</tr>
<tr>
<td></td>
<td><strong>$40 copay</strong> for specialist office visits</td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>10% coinsurance</strong> (after deductible) for professional services you receive at an inpatient or outpatient facility, and any related facility charges</td>
<td></td>
</tr>
<tr>
<td><strong>Urgent Care</strong></td>
<td><strong>$50 copay</strong> per member, per provider, per day for services you receive from a provider that is contracted with the plan network to offer urgent-care services <strong>$20 PCP copay or $40 specialist copay</strong> for office visits or walk-in clinic visits for urgent-care services you receive from an in-network provider that is not specifically contracted for urgent-care services <strong>10% coinsurance</strong> (after deductible) for urgent-care services you receive from any other type of provider</td>
<td><strong>50% coinsurance (after deductible) + balance bill</strong></td>
</tr>
</tbody>
</table>

See the “Emergency Services” row for information about services you receive from certain providers, such as hospitals, that are not specifically contracted with the plan network as urgent-care providers.